

Patient Information

date / /

First name: _____ Last name: _____

Birth Date: _____ SSN: _____ Driver Lic. # _____

Address: _____ Apt. or unit: _____

City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext _____ Cell _____

Marital Status: M D S W Name of spouse: _____

Are you a full time student: _____ Name of school: _____

Referred by: _____

I would prefer to be contacted at: home work cell phone

Payment is due at the time of treatment. Payment plans are only accepted if prior arrangements are made.

Method of payment: Cash Check Credit card

Patient is: Policy Holder
 Responsible Party

Responsible Party/Policy Holder Information (if someone other than patient)

First name: _____ Last name: _____

Address: _____ Apt. Or unit: _____

City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext _____

Birth Date: _____ SSN: _____

Relationship to patient: _____

Responsible party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Ins

Primary Insurance Information

Policy Holder Name: _____ Relationship to patient: _____

Employer: _____ Employer phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Co: _____ Insurance phone: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Group #: _____ Annual deductible: _____ Maximum: _____

Secondary Insurance Information

Policy Holder Name: _____ Relationship to patient: _____

Employer: _____ Employer phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Co: _____ Insurance phone: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Group #: _____ Annual deductible: _____ Maximum: _____

NOTE: It is the patient's responsibility to know and understand their dental insurance benefits. Our office will make every attempt to verify insurance coverage, but due to the tremendous diversity of limitations and exclusions of each insurance plan, we will not guarantee any dental benefits. It is highly recommended that extensive treatment be pre-authorized with your dental insurance company prior to the start of treatment.

HEALTH HISTORY

Name: _____

CIRCLE THE APPROPRIATE ANSWER (leave Blank any question you are unsure of or do not understand)

Yes	No	Is your general health good?	Yes	No	Are you being treated by a physician now?
Yes	No	Has there been a change in your health?	Explain _____		
Yes	No	Have you been hospitalized? When? _____	Date of last physical _____		
		For What? _____	Yes	No	Are you having dental pain?
If yes, circle all that apply: HOT COLD CHEWING OTHER					

YOU HAVE EXPERIENCED:

Yes	No	Bleeding problems, bruising easily	Yes	No	Dizziness, fainting spells
Yes	No	Blurred vision	Yes	No	Dry mouth
Yes	No	Breathing problems	Yes	No	Excessive thirst
Yes	No	Chest pain (angina)	Yes	No	Frequent vomiting, nausea
Yes	No	Difficulty swallowing	Yes	No	Headaches, migraines
Yes	No	Diarrhea, constipation, bloody stool	Yes	No	Hives, rash
Yes	No	Difficulty or frequent urinating	Yes	No	Jaundice
			Yes	No	Joint pain, stiffness
			Yes	No	Persistent cough, coughing up blood
			Yes	No	Recent Weight loss, fever, night sweats
			Yes	No	Seizures
			Yes	No	Shortness of breath
			Yes	No	Sinus problems
			Yes	No	Swollen limbs, ankles

DO YOU HAVE OR HAVE YOU HAD:

Yes	No	AIDS ___ HIV ___	Yes	No	Heart murmur, mitral valve prolapse*
Yes	No	Anemia	Yes	No	Hemophilia
Yes	No	Arthritis, rheumatism, gout	Yes	No	Hepatitis: A ___ B ___ C ___
Yes	No	Artificial Heart Valve*	Yes	No	Herpes: cold sores ___ fever blisters ___
Yes	No	Artificial Joint*	Yes	No	High Blood pressure ___ / ___
Yes	No	Asthma, emphysema, lung disease	Yes	No	Low Blood pressure ___ / ___
Yes	No	Blood disease	Yes	No	Hypoglycemia
Yes	No	Blood transfusion: when _____	Yes	No	Irregular heartbeat
Yes	No	Chemotherapy	Yes	No	Kidney, bladder disease
Yes	No	Congenital heart disorder	Yes	No	Leukemia
Yes	No	Diabetes	Yes	No	Liver disease
Yes	No	Dialysis	Yes	No	Osteoporosis
Yes	No	Heart attack, heart defects	Yes	No	Pacemaker*
Yes	No	Heart disease	Yes	No	Previous endocarditis*
			Yes	No	Psychiatric care
			Yes	No	Radiation treatment
			Yes	No	Rheumatic fever*
			Yes	No	Shingles
			Yes	No	Sickle cell disease
			Yes	No	Stomach problems, ulcers
			Yes	No	Stroke, hardening of arteries
			Yes	No	Thyroid, parathyroid, adrenal disease
			Yes	No	Tonsilitis
			Yes	No	Tuberculosis
			Yes	No	Tumors, cancer, myeloma
			Yes	No	Veneral disease (syphilis, gonorrhea)
			Yes	No	Family history of diabetes, heart problems, cancer

ARE YOU TAKING OR HAVE YOU EVER TAKEN BISPHOSPHONATES, EITHER ORALLY OR BY I.V.? Yes No

Actonel Aredia Boniva Didronel Fosamax Skelif Zometa For how long? _____

ARE YOU TAKING ANY OF THE FOLLOWING:

Alcohol? Quantity _____ Recreational drugs? Type _____ Tobacco? Type/Frequency _____

WOMEN ONLY: (Oral antibiotics have been shown to negate the effectiveness of oral contraceptives)

Are you or could you be pregnant? Nursing? Taking oral birth control?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

<input type="checkbox"/> Acrylic	<input type="checkbox"/> Fruit/Nuts	<input type="checkbox"/> Metal
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Latex	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Other _____
<input type="checkbox"/> Chlorine/Bleach Products		

PLEASE LIST ALL MEDICATIONS (including aspirin, over the counter and herbal remedies) _____

DO YOU HAVE OR HAVE YOU HAD ANY OTHER HEALTH PROBLEMS NOT LISTED? If yes, please explain _____

To the best of my acknowledge, I have answered every question completely and accurately. I understand that this information will remain strictly confidential. I will inform the doctor of any changes in my health and/or medications. I authorize the dental staff to perform, with my informed consent, any necessary dental services I may need during diagnosis and treatment.

Patient signature _____ Date _____

Doctor signature _____ Date _____

RECALL REVIEW: I have reviewed the above information. It remains accurate with no changes to my health or medications.

Patient signature _____ Date _____ Dr. Initial _____

Patient signature _____ Date _____ Dr. Initial _____

Patient signature _____ Date _____ Dr. Initial _____

Dental History

Are you in pain at this time? Yes No

If yes, please describe symptoms, duration, location, intensity, causative factors _____

Name of previous dentist: _____ City: _____

Dentist phone: _____ Date of last visit: _____

What was done? _____ Were xrays taken? _____

Have you had a full set of xrays (18 films) or a panorex film within the last 5 years? _____

Do you have, or have you had, any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Gum pain/sensitivity | <input type="checkbox"/> Constant bad taste |
| <input type="checkbox"/> Jaw Joint Pain | <input type="checkbox"/> Difficulty chewing |
| <input type="checkbox"/> Swelling or unusual lumps | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Teeth Grinding or Clenching | <input type="checkbox"/> Loose teeth |
| <input type="checkbox"/> Popping or clicking when opening/chewing | <input type="checkbox"/> Chew on one side |
| <input type="checkbox"/> Food wedges between teeth | |
| <input type="checkbox"/> Sensitivity: <input type="checkbox"/> Sweet <input type="checkbox"/> Hot <input type="checkbox"/> Cold | <input type="checkbox"/> Biting |
| <input type="checkbox"/> Blisters: <input type="checkbox"/> on lips <input type="checkbox"/> inside mouth | |

What is your primary concern regarding your dental treatment? _____

Ideally, if time, effort, and expense were of no consequence, what would you like to have done concerning your dental condition?

“If there is any additional information that the Doctor may need to know in order to treat me safely and effectively, I will personally discuss it with the Doctor.

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dental staff to help determine appropriate and healthful dental treatment. Since at each visit a treatment plan will be presented and the work to be done is explained to me before treatment is begun, I give the doctor my consent to perform any needed dental treatment.

I authorize my insurance company to pay to Dr. Trester all insurance benefits for services rendered.

I authorize Dr. Lee to release all information necessary to secure benefits from my dental insurance.

I understand that I am fully responsible for ALL services whether covered or not covered or denied by my insurance company.”

Patient signature _____ Date _____

(Parent or guardian if patient is a minor)